

8908

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cabret</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind</i> b. COUNTY <i>Cabret</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>	
c. LENGTH OF STAY IN TB <i>2 days</i>		d. STREET ADDRESS <i>—</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cabret County Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Nethie L. Bond</i>		4. DATE OF DEATH Month <i>Aug.</i> Day <i>2</i> Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 15 1887</i>
9. AGE (In years last birthday) <i>70</i> yrs.		10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Cabret Co., Ind</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Richard L. Lyles</i>		14. MOTHER'S MAIDEN NAME <i>Frances Jane Freeland</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>	
17. INFORMANT <i>Mr. George D. Turner</i>		Address <i>Prince Frederick Ind.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pyelonephritis</i> <i>260X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Parkinson's disease (part treated) 9 years</i> DUE TO (c) <i>Diabetes Mellitus</i> <i>3 months</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July</i> , 19 <i>59</i> , to <i>Aug</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Aug 1</i> , 19 <i>58</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Dr. Jett</i> M.D.		PRINCE FREDERICK <i>5/18</i>	
PHYSICIAN'S NAME (Type) <i>DR. C. JETT</i>		PRINCE FREDERICK	
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Aug. 4, 1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Old Saints Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Sunderland - Cabret Co - Ind</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Warkner &amp; Son - Mutual, Ind.</i>		24. REC'D BY REGISTRAR DATE <i>AUG 6 '58</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Olden</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8408

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
JAMES H. SMITH		Male		45		White		Jan 15, 1910		Baltimore, Md.	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. PLACE OF DEATH		11. DATE OF DEATH		12. TIME OF DEATH	
Teacher		Heart Disease		Natural		Home		Jan 20, 1955		8:30 AM	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESS		16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF CLERK	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
19. MEDICAL HISTORY		20. SOCIAL HISTORY		21. FAMILY HISTORY		22. PRESENT ILLNESS		23. TREATMENT		24. PROGNOSIS	
[Text]		[Text]		[Text]		[Text]		[Text]		[Text]	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND HUMAN SERVICES. IT IS NOT VALID FOR THE PURPOSES OF THE FEDERAL GOVERNMENT OR ANY OTHER AGENCY.

8909

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>				c. LENGTH OF STAY IN 1b <b>X North Beach</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Calvert County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Patrick Thomas Patrick Carton</b>				4. DATE OF DEATH Month <b>August</b> Day <b>2</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/8/93</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew Carton</b>				14. MOTHER'S MAIDEN NAME <b>Roseanna McGuire</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Family</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure -</b> <b>153.0</b> DUE TO <b>Carcinomatous - Ca. of Caecum.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>3 Months</b> (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Aspartame poisoning - July 23 - 24 - 25 - 26 - 27 - 28 - 29 - 30 - 31 - 1958</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 20</b> , 19 <b>58</b> , to <b>Aug 2</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Aug 2</b> , 19 <b>58</b> , and that death occurred at <b>7:40</b> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R de Villarreale</b>				ADDRESS (Street, city or town, state) <b>St Leonard</b>			
PHYSICIAN'S NAME (Type) <b>R de Villarreale</b>				DATE SIGNED <b>8/1/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 6, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Harmony Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Harmony, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. A. Harkness &amp; Son - Mutual, Md.</b>				24a. REC'D BY REGISTRAR <b>AUG 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8910

CERTIFICATE OF DEATH

08909

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Cabret</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Ind</i> b. COUNTY <i>Cabret</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick (rural)</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cabret County Hospital</i>		e. STREET ADDRESS <i>—</i>	
3. NAME OF DECEASED (Type or print) First <i>ERNEST</i> Middle <i>DENTON</i> Last <i>DENTON</i>		4. DATE OF DEATH Month <i>Aug.</i> Day <i>24</i> Year <i>1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 12, 1874</i>
9. AGE (In years, last birthday) <i>83</i> yrs.		IF UNDER 1 YEAR: Months <i>10</i> Days <i>12</i> Hours <i>—</i> Min. <i>—</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm Owner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
11. BIRTHPLACE (State or foreign country) <i>Cabret Co., Ind.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Denton</i>		14. MOTHER'S MAIDEN NAME <i>Henrietta Hutchins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>220-09-4248</i>	
17. INFORMANT <i>Ernestine Boyd-Pr. Frederick, Ind.</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis C.V. Disease</i> DUE TO (c) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug 16</i> , 19 <i>58</i> , to <i>Aug 24</i> , 19 <i>58</i> , that I last saw the deceased alive at <i>Aug 24</i> , 19 <i>58</i> , and that death occurred at <i>—</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Page Spitt</i>		ADDRESS (Street, city or town, state) <i>Prince Frederick, Ind.</i>	
PHYSICIAN'S NAME (Type) <i>PAGE C JETT</i>		DATE SIGNED <i>9/1/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug. 27, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Water's Memorial Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Cabret County, Ind.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. G. Harkness</i>		ADDRESS <i>Gen. Mutual, Ind.</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Charles E. Hume</i>	
DATE <i>AUG 27 '58</i>			





8911

## CERTIFICATE OF DEATH

Reg. Dist. No.

08910

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>				c. LENGTH OF STAY IN 1b <b>X Lusby</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Calvert County Hospital</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Rebecca</b> First <b>Katie</b> Middle <b>Edwards</b> Last				4. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 16, 1878</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>	
13. FATHER'S NAME <b>John W. Longs</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca C. Roberts</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>214-36-8045</b>		17. INFORMANT <b>Goldie Hall, Lusby, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>C.V.R. disease</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4 Mar</b> , 19 <b>58</b> , to <b>3 Aug</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3 Aug</b> , 19 <b>58</b> , and that death occurred at <b>7 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Huntingtown Md</b> DATE SIGNED <b>Green</b>							
ACTUAL SIGNATURE <b>Green</b>				M.D. <b>Huntingtown Md</b>			
PHYSICIAN'S NAME (Type)							
22a. (BURIAL) CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>8-9-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>		22d. LOCATION (City, town, or county) (State) <b>Lusby, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. E. Sewell, Ph. Fred m d.</b>				24a. REC'D BY REGISTRAR <b>Aug 11 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Albrecht</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4

Information Systems

0123456789

Collette Hall, 1901



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08911

8912

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Calvert</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL OR give nearest town) <i>Prince Frederick</i>		LENGTH OF STAY (in this place) <i>2 days</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Benedict</i>		<i>08X-2</i> ✓	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Calvert County Hospital</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>Bessie Mae Higgs</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>8 15 19 58</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Self</i>	8. DATE OF BIRTH <i>10/21/00</i>	9. AGE last birthday <i>57</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Springfield</i>				14. MOTHER'S MAIDEN NAME <i>Alice Bond</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT & ADDRESS <i>Mary Alice Murphy - daughter - Benedict</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
190.5 IMMEDIATE CAUSE (A) <i>Carcinoma of the</i>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <i>metastasis from melanoma</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>(abdomen) / metastasis in thorax</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>x pubis</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>9 AM</i> , 19 <i>5</i> , to <i>8/15</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>8/15</i> , 19 <i>58</i> , and that death occurred at <i>6:25 P.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Ed Williams</i>				ADDRESS (Street, city, town, state) <i>St. Leonard, Md.</i>		DATE SIGNED <i>8/16/58</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>8/18/58</i>		NAME OF CEMETERY OR CREMATORY <i>St Marys</i>		LOCATION (City, town, or county) (State) <i>Bryantown, Md.</i>	
24. REC'D BY REGISTRAR <i>AUG 20 58</i>		REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>			



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## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8913

## CERTIFICATE OF DEATH

08912

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Valvert</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Prince Frederick</u>		LENGTH OF STAY (in this place) <u>3 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Island Creek</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Grace</u>		(Middle)		(Last) <u>Holland</u>		(Month) (Day) (Year) <u>August 22 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4/29/14</u>	9. AGE last birthday <u>44</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wesley Gross</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Parker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mother</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <u>Cerebral accident due to</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Essential Hypertension c.v.d.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 22, 1958</u> , to <u>Aug 22, 1958</u> , that I last saw the deceased alive on <u>Aug 22, 1958</u> , and that death occurred at <u>8:45</u> M., from the causes and on the date stated above.							
SIGNATURE <u>R. E. Sewell</u>		M.D.		ADDRESS (Street, city, town, state) <u>St. James</u>		DATE SIGNED <u>8/24</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>8-26-58</u>		NAME OF CEMETERY OR CREMATORY <u>Brooks</u>		LOCATION (City, town, or county) (State) <u>Island Creek</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>SEP 3 '58</u>		<u>R. E. Sewell</u>		<u>P. E. Sewell, Jr. Fred, Md</u>			

# CERTIFICATE OF DEATH

2013

DATE OF DEATH

TO REPORT: (Check one) ☐ Hospital ☐ Home ☐ Other

NAME OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH (List all causes, beginning with immediate cause)

DATE OF DEATH

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9.5.2013  
J. E. Smith, M.D.  
J. E. Smith, M.D.

8-20-28

( )  
J. E. Smith, M.D.

2013

## CERTIFICATE OF DEATH

08913

Reg. Dist. No.

8914

1. PLACE OF DEATH o. COUNTY <b>Calvert</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>New York</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bronxville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Calvert County Hospital</b>		d. STREET ADDRESS <b>89 Lawrence Park</b>	
3. NAME OF DECEASED (Type or print) <b>Thomas Hamilton Niven</b>		4. DATE OF DEATH <b>August 3, 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 1, 1958</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Andrew Niven</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hamilton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>Mary Niven, Bronxville, N. Y.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pre-mature delivery.</b> <b>761.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Placenta previa</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 Aug</b> , 19 <b>58</b> , to <b>3 Aug</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3 Aug</b> , 19 <b>58</b> , and that death occurred at <b>12:35</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. J. Weems</b>		ADDRESS (Street, city or town, state) <b>Huntingtown, Md</b>	
PHYSICIAN'S NAME (Type) <b>G. J. WEEMS</b>		DATE SIGNED <b>8/4/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Aug. 5, 1958</b>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's</b>	22d. LOCATION (City, town, or county) (State) <b>Prince Frederick, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. A. Warkner &amp; Son - Mutual, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. ...</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 6 '58</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and fill with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08914

8915

CERTIFICATE OF DEATH

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>Calvert</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Willows</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>County Hosp</u>		STREET ADDRESS (If rural give location) <u>Willows</u>	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Mary Reid</u>		<b>4. DATE OF DEATH</b> (Month) <u>8</u> (Day) <u>27</u> (Year) <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>March 1872</u>
9. AGE last birthday <u>86</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Amos Bradley</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>Carl Brown Willows</u>			
<b>18. MEDICAL CERTIFICATION</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
442X IMMEDIATE CAUSE (A) <u>Cardiovascular Renal Disease</u>		<u>5 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Age</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Found in home circumstances</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>May 27, 1958</u>, to <u>8/27, 1958</u>, that I last saw the deceased alive on <u>8/26</u>, 19<u>58</u>, and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.</b>			
SIGNATURE <u>H. W. Ward</u>		DATE SIGNED <u>8/28/58</u>	
M.D.		ADDRESS (Street, city, town, state)	
23. BURIAL/CREMATION, REMOVAL (SPECIFY)		24. NAME OF CEMETERY OR CREMATORY	
DATE THEREOF <u>8-29-58</u>		LOCATION (City, town, or county) (State)	
25. REC'D BY REGISTRAR		26. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>		ADDRESS <u>P.E. Sewell, Prince Frederick.</u>	
DATE <u>SEP 3 '58</u>			

CERTIFICATE OF DEATH

8815

LEGAL ATTENDANCE: NAME OF DECEASED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A5C 1-55 10M

Item 21b Film 232 8-20-58

Item 7 Film 232 8/15/58

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08915

8916

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA Calvert</u>	
CITY OR TOWN <u>Brown Fred</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Severn</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Frederick Gen'l Hosp.</u>				STREET ADDRESS			
<b>3. NAME OF DECEASED</b>				<b>4. DATE OF DEATH</b>			
(First) <u>Clara</u>		(Middle) <u>F</u>		(Last) <u>Westerman</u>		(Month) (Day) (Year) <u>Aug 8 19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug 6 1868</u>	9. AGE last birthday <u>90</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Music Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick Westerman</u>				14. MOTHER'S MAIDEN NAME <u>Clara</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs James Valiant, Olney, Md.</u>			
15. (If Yes, give war or dates of service) <u>none</u>							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
9040 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Fracture of hip</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) <u>Fell at home</u>		21c. WHERE DID INJURY OCCUR? (City or town) <u>Severn</u> (County) <u>AA</u> (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR? <u>Fell at home</u>			
<b>22. I hereby certify that I attended the deceased from</b> <u>7/27</u> , 19 <u>58</u> , to <u>8/8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/2</u> , 19 <u>58</u> , and that death occurred at <u>1:30</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>ASW</u>				DATE SIGNED <u>8 Aug 58</u>			
M.D. <u>Severingtown Md</u>				ADDRESS (Street, city, town, State)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug. 11, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>		LOCATION (City, town, or county) <u>Baltimore, Md.</u> (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur S. Knight</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James S. Hopping and Kirkley Glen Burnie, Md.</u> ADDRESS			
DATE <u>AUG 12 1958</u>							

